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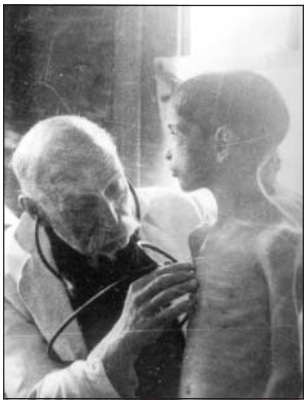
This week in the BMJ

Prolonged starvation results in more cardiovascular disease

Prolonged starvation results, three to six decades later, in raised blood pressure and higher mortality from heart disease and stroke. Sparén and colleagues (p 11) followed up nearly 4000 men from St Petersburg (formerly Leningrad) from 1975 to 1999; a third had lived through the siege of the city during the second world war. They found that a higher proportion of those who had starved for a long time had cardiovascular diseases and increased mortality, particularly if they were aged 9 to15 at the time of the siege. Wars and starvation continue, and severe starvation, accompanied by stress and trauma, may increase cardiovascular disease, especially if it occurs during puberty.



A stable partner slows progression of HIV

In people infected with HIV, having a stable partner slows the progression of disease. During three years' follow up of 3736 HIV positive Swiss

SILVIA OTTE/PHOTONICA

patients who had received highly active antiretroviral therapy, Young and colleagues (p 15) found that 80% of the patients had a stable partner at some time, and these patients had a slower rate of progression to AIDS or death. Though having a stable partner results in lower mortality in HIV positive patients, the mechanisms responsible are not known.

CT scanning in infancy may affect later learning

Receiving low doses of ionising radiation to the head in infancy may impair the developing brain and affect intellectual development. Hall and colleagues (p 19) studied 3094 men from Sweden who had received radiotherapy for cutaneous hemangioma before the age of 18 months. They analysed military records reporting the men's intellectual capacity at age 18 or 19 and found that exposure to doses of radiation greater than 100 mGy, the equivalent of a computed tomography scan, was negatively correlated with high school attendance and learning ability assessed by cognitive tests. The authors call for re-evaluating the use of computed tomography for minor head injuries in infants.

Poor reporting of trials does not mean poor quality trials

Poor reporting of methods may not reflect on a trial's quality. Soares and colleagues (p 22) compared the published reports of 56 randomised controlled trials conducted by the Radiation Therapy Oncology Group with the original research protocols. They found that important methods—sample size calculations, concealment of allocation, and intention to treat analysis—were often not mentioned in the final report but had been explicitly stated in the research protocol. The publication of protocols may improve the quality of conducting and reporting clinical research, the authors say, and contacting the trialists may provide additional information when the research is used in meta-analyses.

Volunteer support does not change breastfeeding rates

Support from volunteer counsellors failed to extend the period during which women breast fed. Graffy and colleagues (p 26) conducted a randomised controlled trial of 720 women who planned to breast feed their baby. The women were allocated either to additional volunteer support or usual care. The duration of breast feeding was the same in both groups, and less than two thirds of women were still breast feeding after six weeks. Many of those who stopped breast feeding did not contact their counsellor, but those women who did valued her support. The authors say that, particularly in the first few days after the birth, provision of support for breast feeding should be routine rather than depend on a call for help.

Omega 3 fatty acids can protect against heart disease

DAN HOLMBERG/PHOTONICA

Omega 3 fatty acids, which are found in fish and fish oils, can protect against coronary heart disease, but optimal intake is not firmly established. In a clinical review, Din et al (p 30) examine the evidence regarding the intake of fish oils and the risk of coronary disease. They outline the mechanisms through which fish oils might confer cardiac benefits (reduced arryhthmias, enhanced stability of atherosclerotic plaque, and reduced platelet aggregation) and consider recent guidelines for fish consumption. Currently the evidence is strongest for patients who had myocardial infarction.

POEM*

Discontinuing aspirin or warfarin is optional for cataract surgery

Question Should anticoagulants and antiplatelet agents be stopped before cataract surgery?

Synopsis In theory, having cataract surgery while taking anticoagulants might increase the risk of ocular haemorrhage. Is there any benefit to continued anticoagulation? Although this isn't the best possible study, it is the best available evidence to date on this question. In this cohort study, the authors looked at all patients undergoing cataract surgery who were older than 50 years and had no history of acute myocardial infarction and whose surgery used general anaesthesia. Patients who took aspirin were considered to have stopped if their last dose occurred 14 days before surgery, and those who took warfarin were considered non-users if the last dose occurred four days before surgery. Of 19 354 patients undergoing 20 775 operations, 94.1% agreed to participate, and 99.8% of the participants provided an interview seven days after the surgery. Regarding aspirin, 76.7% did not routinely use aspirin, 5.2% used aspirin and discontinued its use, and 18% continued to use aspirin through surgery. Regarding warfarin, 96.1% did not use it, 1.1% discontinued use, and 2.8% continued use. There was no significant difference between groups in the risk of ocular haemorrhage between patients who continued or discontinued aspirin, and no ocular haemorrhage occurred among warfarin users. The risk of myocardial infarction, haemorrhagic cystitis, myocardial ischaemia, stroke, or deep vein thrombosis did not differ. If anything, there was a slightly greater risk for those who continued use of warfarin and aspirin, perhaps because the providers felt that their patients were at increased risk.

Bottom line It seems that continued use of warfarin or aspirin puts patients at little risk of ocular haemorrhage during cataract surgery. Conversely, the risk of thromboembolic or cardiovascular events does not seem to be increased if these agents are discontinued.

Level of evidence 2b (see www.infopoems.com/resources/levels.html). Individual cohort study or low quality randomised controlled trials (<80% follow up).

Katz J, Feldman MA, Bass EB, et al. Risks and benefits of anticoagulant and antiplatelet medication use before cataract surgery. *Ophthalmology* 2003; 110:1784-8.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

A tough time for paediatricians

Paediatrics is a highly attractive specialty but also, as this issue shows, a tough one. Disease in the young is protean. Evidence is often lacking. The wrong intervention may lead to a lifetime of damage. And the sociology is complex: everybody is supposed to love children, but they are regularly abused. The British, for example, object vociferously to European attempts to stop them beating their children. "It never did me any harm," is the cry from people whose looks and behaviour belie their conviction.

One of Britain's most eminent paediatricians, Sir Roy Meadow, has been reported to the General Medical Council, the body that regulates British doctors, for his role as a prosecution witness in three trials where mothers were wrongly convicted of killing their babies (p 9). These convictions have all been overturned in the past year, and there may be a review of all cases in which Meadow gave evidence.

Meadow was one of the first to argue that some seeming cot deaths were the result of mothers deliberately harming their babies. There is no doubt that this happens, and little is more uncomfortable than the thought of a mother killing her child. But are such cases best dealt with by the courts? Giving evidence in such inevitably cloudy cases must be hard, particularly when the courts demand a binary outcome of guilty or not guilty. The process must be excruciating for the accused, their families, and those who must assemble and give evidence. The uncertainty that is normal in medicine clashes with the need of the courts for a certain answer.

The clash is further illustrated by a judge suggesting that photographs taken by colposcopy should not be used for second opinions in cases of possible child sex abuse (see bmj.com news extra). Doctors who examined a young girl judged that her hymen had been torn, and two experts who examined photographs agreed. Authorities have advised using photographs in order to avoid the trauma of further examinations, but when in the course of an appeal the two experts eventually examined the girl they decided her hymen was not torn.

Paediatric evidence of a different sort has come into question with the Committee on the Safety of Medicines advising against the use of most selective serotonin reuptake inhibitors (SSRIs) in people aged under 18 who are depressed (p 3). The fear is that the drugs may increase suicidal thoughts. The real problem is that there is hardly any research with these drugs in young people. The 40 000 or so children and adolescents in Britain taking antidepressants are doing so on the basis of evidence from a few hundred people.

If all this wasn't enough for paediatricians to worry about, in Britain they have also had to cope with the consequences of a television drama that seemed to strongly support the arguments that the measles, mumps, rubella (MMR) vaccine causes autism (p 50). Exactly what those consequences will be we must wait and see.

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